LSU Health NEW ORLEANS
School of Allied Health Professions

Professional Services Agreement Information Form

To be completed by Department Coordinator or Clinic Manager
This form is required to initiate the process of establishing a new Professional Services Agreement (PSA) or renewing an existing one. Please complete all sections and submit the form to the Business Manager of the School of Allied Health Professions.

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1. Contracting Agency Contact Information
(*Please provide at least one contact person.*)

- **Primary Contact Name:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Legal Name of Agency:** _____
- **Agency Address:** _____
- **List of deliverables, if applicable**: _____
- **Name of Authorized Signatory:** _____

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2. Scope of Services
(*Please describe all services to be provided by our faculty.*)

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3. Date of Service
(*If this is a one-time agreement, specify the date of service.*)
Date: _____

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4. Time and Duration of Event
(*If this is a one-time agreement, specify the start time and expected length.*)
Start Time: _____
Length of Event: _____

5. Estimated Compensation Rate
(*Business Office will negotiate fair market value rate. If available, please provide current or projected compensation rate.)*
Amount: _____ (hourly or fee for service)

6. Invoicing
(Who will be invoicing the contracting agency?)
Department ☐ Clinic Operations Manager ☐

Review & Approvals:

Servicing Faculty **Department Head or Delegate**

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